Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Medicaid Enrolled Providers of Outpatient Rehabilitation Services and Managed Care Organizations Participating in the Virginia Medical Assistance Programs

FROM: Cynthia B. Jones, Acting Director
Department of Medical Assistance Services

MEMO: Special

DATE: 06/29/2010

SUBJECT: Notice of Service Authorization Requirements for Outpatient Rehabilitation Services Provided by Physicians and Professionals – *Effective August 1, 2010*

The purpose of this memorandum is to inform providers of Outpatient Rehabilitation Services under the Fee-for-Service (FFS) Medicaid/FAMIS program, specifically physicians and professionals, that effective August 1, 2010, service authorization (SA) is required prior to service delivery and claims submission after the initial five units in the state fiscal year. Service authorization is to be obtained through KePRO, the service authorization contractor for the Department of Medical Assistance Services (DMAS).

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCOs). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may reimburse differently than as described for Medicaid or FAMIS fee-for-service individuals. For more information, please contact the MCO directly.

Item 297 QQQ of the 2010 Appropriations Act directed the Department to establish limits for rehabilitation services provided in all settings by all providers. DMAS is implementing the intent of this language through the expansion of service authorization to providers previously excluded from that process. Medically necessary therapies will continue to be reimbursed after service authorization has been obtained (based on the process outlined below).

All providers of Outpatient Rehab services may obtain information on how to request service authorization for these services on KePRO's website. To attend a scheduled web based training, go to the KePRO website, https://dmas.kepro.org, click on the *Training* tab and you will see the

Scheduled Training Live and Recorded link. This will take you to the calendar for live sessions, and the list of recorded sessions.

Registration is not required to attend KePRO's live web presentations, but space is limited to 100 attendees. All recorded trainings are available 24/7.

The following procedure codes for Outpatient Rehabilitation services require SA and are the only procedure codes accepted for dates of service August 1, 2010 and forward when submitting claims. All other therapy codes will be denied for edit "0426 – Service May Be Covered Under Another Code, Bill Other Code"; these codes are listed on the table below so that providers can crosswalk these codes to the allowable codes and bill Medicaid accordingly. For example, after August 1, 2010, code 97010 will be denied; the provider should bill Medicaid under either 97110 or 97530, depending on the type of therapy.

HCPC Procedure Code	Service Definition	CPT Codes Disallowed Effective July 31, 2010	Number of Units per Fiscal Year* Without PA	DMAS Fee Schedule Amount Effective July 1, 2010 for Physician/ Practitioner Providers
97110	Therapeutic procedure (PT), each 15 minutes **Note:** 1 unit = 15 minutes	97010 – 97028, 97032 – 97036, 97112 – 97124, 97140, 97532, 97533	5/recipient per fiscal year, regardless of the number of providers	$22.38
97150	Therapeutic procedure(s) (PT), group **Note:** 1 unit = a group session			IC
97001	Physical Therapy evaluation **Note:** 1 unit = evaluation	97002		$55.53
97530	Therapeutic activities (OT), each 15 minutes **Note:** 1 unit = 15 minutes	97010 – 97028, 97032 – 97036, 97112 – 97124, 97140 , 97532, 97533	5/recipient per fiscal year, regardless of the number of providers	$24.08
S9129	Therapeutic procedure(s) (OT) group **Note**: 1 unit = a group session			IC
97003	Occupational therapy evaluation **Note:** 1 unit = an evaluation	97004		$59.79
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual **Note:** 1 unit = 1 treatment session		5/recipient per fiscal year, regardless of the number of providers	$50.15
92508	Treatment of speech, language, vice, communication, and/or auditory processing disorder; group (2 or more individuals) **Note**: 1 unit = 1 treatment session			$24.65
92506	Evaluation of speech, language, voice, communication, and/or auditory processing **Note:** 1 unit = an evaluation			$121.27

* Medicaid State Fiscal Year is defined as July 1 through June 30 of every year.

Providers must perform an initial evaluation for new cases. Evaluation units are included in the five unit service limit without service authorization. After these initial 5 units are provided, individuals may receive additional units, for up to 12 month increments, with service authorization through KePRO. Once the units that do not require service authorization are used, all subsequent units require SA through June 30th of each year in order for claims to pay. The units that do not require SA are renewable annually, July 1st of each year. All individuals will require SA after the five unit service limit is exhausted in order for claims with dates of service August 1, 2010 and forward to pay. Retroactive authorization will only be granted in the case of retroactive Medicaid eligibility determination. Providers may determine utilization of prior units used by using the MediCall or ARS systems identified at the end of this memorandum.

B. Criteria for Determination

Decisions will be made utilizing *McKesson InterQual® Criteria, Rehabilitation: Adult and Pediatric.* Please refer to DMAS' *Rehabilitation Manual* for more detailed information regarding the Outpatient Rehabilitation program and billing requirements. To access this manual on the DMAS website, go to www.dmas.virginia.gov, scroll down to *Provider Services*, click on *Provider Manuals*, go to *Available Manuals* (drop down menu) and select *Rehabilitation*.

C. Final Determination Decisions

Providers will begin receiving their official authorization determinations (denials or approvals) via the ACS automated letter generation process. The letter generated from ACS will include a SA number. This number must be used when submitting claims. Claims submitted for services that exceed the units authorized will be denied.

How to Submit Requests through KePRO

KePRO will accept requests for SA via iEXCHANGE™, a web based portal for providers to directly enter requests and data via the web. All SA requests may be submitted to KePRO through iEXCHANGE™. You must have a provider iEXCHANGE™ account before submitting information through iEXCHANGE™.

To register for an iEXCHANGE™ account, you must know the following. Do not start this process until you have the following information in hand:

1) The address where the provider's Remittance Advice (RA) and payment is mailed;
2) The last RA payment date; and
3) The provider's 1099 amount displayed on the last page of the last RA.

It may be necessary to contact your agency's Business Office or Billing Department for this information or have that department complete the registration process. You may register at https://dmas.kepro.org/default2.aspx. You will be prompted through the registration process and assigned a password after registering. Your password will be sent via e-mail and may take up to 10 business days to receive after completing the registration process. Once you receive your

password, you will be able to set up your account, re-set pass-codes for users, specify users within your organization and their specific access, and customize your account.

Using iEXCHANGE™ has many advantages. Among the benefits are:

- Eliminating transcription errors by KePRO;
- Eliminating rejected cases because basic demographic information is not included;
- Increasing speed of reviewer access to SA requests – cases submitted go directly to a review queue;
- Confirmation of successful submissions occurs in real time at the time of submission; and
- SA requests, updates and case viewing are available 24/7 from virtually anywhere high speed internet access is available. Once a SA number has been generated, it is available for viewing in iEXCHANGE™.

To submit requests via iEXCHANGE™, log on to DMAS.KePRO.org and register for a provider web account.

KePRO will offer frequent trainings regarding iEXCHANGE™ account set-up and information on how to submit requests via iEXCHANGE™. Please visit KePRO's website for specific training information/schedules and a directory of available trainings that can be viewed at your convenience, including how to navigate the iEXCHANGE™ system at: https://dmas.kepro.org/. Click on the *Training* tab where you will see a link to *Scheduled Training Live and Recorded* as well as a listing by review type of all training documents available for reading and download.

KePRO has developed helpful sheets *"Required SA Information"* sheets for SA requests. These sheets will be available on the KePRO website at https://dmas.kepro.org prior to August 1, 2010. The purpose of these 'help sheets' is to assist providers regarding the type of clinical information needed by KePRO to review each request, and how to provide concise, focused SA requests with appropriate clinical information. These help sheets may be used as a tip sheet for all of the important items to address in your request or can be used as a template for your actual request – simply edit, copy, and paste into iEXCHANGE™. Using these sheets and referring to them during the submission process will decrease the number of cases pended by KePRO for missing or additional information, and speed up the processing time.

Pending Decisions

KePRO will pend requests that require additional information before rendering a final determination. Notifications of pended requests may be viewed in iEXCHANGE™ when you go into your submitted case. Providers are required to respond to KePRO's request for additional information as quickly as possible to continue processing the request. The provider has three business days to provide the additional clinical information or the request will be denied.

Denials that do not meet clinical criteria will automatically route to a physician reviewer for reconsideration. The physician reviewer will review all information submitted, and render a final determination. If the physician reviewer determines a denial, the decision will be entered in the Medicaid Management Information System (MMIS), where appeal rights will automatically be generated on the letter to providers and include directions on how to appeal the decision.

Resource Information

Should you have any questions regarding the service authorization process, please send your inquiries via e-mail to providerissues@kepro.org or PAUR06@dmas.virginia.gov.

All other Medicaid provider issues not related to service authorization should be addressed through the Provider Helpline. The numbers are 1-800-552-8627 or if you are located in Richmond or out-of-state call 804-786-6273.

For information regarding the transition of Virginia Medicaid fiscal agent and provider enrollment services to ACS State Healthcare (ACS), please refer to the Medicaid Memo entitled "*Transition of Virginia Medicaid Fiscal Agent and Provider Enrollment Services to ACS State Healthcare (ACS) – UPDATED*" , dated May 26, 2010.

REQUESTS FOR DUPLICATE REMITTANCE ADVICES

In an effort to reduce operating expenditures, requests for duplicate provider remittance advices are no longer printed and mailed free of charge. Duplicate remittance advices are now processed and sent via secure email. A processing fee for generating duplicate paper remittance advices has been applied to paper requests, effective July 1, 2009.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.